North Carolina Department of Health and Human Services
Division of Medical Assistance - Provider Services
2501 Mail Services Center
Raleigh NC 27699-2501

801Ruggles Drive
Raleigh NC 27603

Dear Applicant

Thank you for your interest in providing additional services as a Community Intervention Services (CIS) Agency provider with the NC Medicaid Program. In order for us to add these services, you must receive additional endorsement prior to submitting the following:

Group Applicant

- Addendum to North Carolina Provider Participation Agreement for a Community Intervention Services (CIS) Agency. Original Signature Required. White out and alterations are not accepted. Please do not highlight any information on the addendum.
- Copy of Approval Letter by CDSA/DPH for Early Intervention Services (if applicable).
- Copy of Certificate of Accreditation (if applicable i.e. JCAHO, CARF).
- Copy of Notification of Endorsement Action by LME or Accreditation Letter issued by DPH.
- Name on addendum must exactly match name on original Medicaid Participation Agreement.
- Provider completes and signs the addendum and returns along with the required credentials to:

  DMA Provider Services
  Attn: CIS Provider Enrollment Specialist
  2501 Mail Services Center
  Raleigh, NC 27699-2501

Providers are requested to include on their addendum the name, e-mail address, and fax number of the individual at their site that is responsible for receiving Medicaid information.

Providers will be notified by mail once these additional services have been approved for enrollment. Please do not submit claims for any services until you have received notification of your provider number, and its effective date. Billing information and medical coverage polices are available on DMA's website at http://www.dhhs.state.nc.us/dma/prov.htm.

Thank you again for your interest, if you have any questions or need additional information, please feel free to contact your CIS Provider Enrollment Specialist at 1-919-855-4050. We are also on the Web at http://www.dhhs.state.nc.us/dma/

North Carolina Department of Health and Human Services
Div ision of Medical Assistance - Provider Services - 919-855-4050
Community Intervention Services (CIS) Agency

STATE USE ONLY
[ ] Initial Enrollment
[ ] Re-enrollment
[ ] CHOW
[ ] Other Change

ADDENDUM TO NORTH CAROLINA PROVIDER PARTICIPATION AGREEMENT

This addendum shall become part of your participation agreement with the NC Medicaid Program. As an approved Medicaid Provider of Community Intervention Services, I herby submit this Addendum and a copy of my Certification of Endorsement by the LME or Accreditation letter issued by the DPH or the LME to add the following services of which our agency has received endorsement.

Current CIS Provider Core Number: 83 ☐☐☐☐☐

Indicate the Community Intervention Services your business/agency is adding:

- ☐ Assertive Community Treatment Team
- ☐ Community Support Services
- ☐ Partial Hospital
- ☐ Mobile Crisis Management
- ☐ Intensive In Home
- ☐ Child and Adolescent Day Treatment
- ☐ Psychosocial Rehabilitation
- ☐ DD Targeted Case Management
- ☐ Ambulatory Detoxification
- ☐ Non Hospital Detoxification
- ☐ Opiod Treatment
- ☐ Diagnostic Assessment
- ☐ Multisystemic Therapy (MST)
- ☐ Community Based Rehabilitative Service – Early Intervention
- ☐ Professional Treatment Services in Facility Based Crisis Programs
- ☐ Substance Abuse Intensive Outpatient Program
- ☐ Substance Abuse Non Medical Community Residential Treatment
- ☐ Substance Abuse Medically Monitored Community Residential Treatment
- ☐ Substance Abuse comprehensive Outpatient Treatment Program
- ☐ Medically Supervised or ADATC Detoxification/Crisis Stabilization

Type or Print All Information in Blue or Black Ink

Name of Provider (must exactly match the name on Medicaid Participation Agreement):

_____

Doing Business As (if applicable): _____

Telephone Number: (_____) _____ - _____

Fax Number: (_____) _____ - _____

Email Address:_____

Site Address: _____
Street

_____ _____
City & State Zip Code + Four (Last 4 digits required)

County: _____

Payment/Mailing Address: _____
Street or Post Office Box

_____ _____
City & State Zip Code + Four (Last 4 digits required)

Contact Person's Name:_____

Contact Person's Telephone Number: (_____) _____

CERTIFICATION STATEMENT:

The Undersigned certified the following:

- Provider attests that the contents of this application are true, accurate, and complete.
- There has been no: Change in ownership
  Site, location or agency
  Tax reporting or agency
- Provider understands that some changes may require additional information or a new application process.
- All information on file with the Division of Medical Assistance is current and correct.
- I agree to abide by the laws, regulations and program guidelines applicable to the services I have hereby applied to render.
- Provider certifies that they meet the qualifications and standards defined in the services definitions for the services herein requested.
- Providers agrees to provide such services within the guidelines of the most current service definitions(s) approved by the Division of Medical Assistance.

Signature of Authorization Required:

****UNSIGNED AGREEMENT WILL NOT BE PROCESSED****

I certify that the above information is true and correct. I further understand that any false or misleading information may be cause for denial or termination of participation as a Medicaid Provider. Individual agreements must have the provider's original signature. Authorized agents can only sign for group agreements.

_____ _____
Signature of Applicant or Authorized Agent **Date**

_____ _____
Printed Name and Title **Fiscal Year End Date**

INTERNAL USE BY THE DIVISION OF MEDICAL ASSISTANCE

EFFECTIVE DATE:

This agreement is executed and shall become effective on the _____ day of _____ in the year of _____.

The agreement shall remain subject to renewal on a periodic basis. A new agreement may be required as DMA necessitates, by operation of law, Medicaid regulations, polices or other material circumstances, or termination upon substitution of a new agreement, or by act of the parties as herein provided. You are herein authorized to provider services of which are in accordance with the approved services definitions.

DMA APPROVAL:
Accepted on _____ by _____